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Supreme Court, U.S.
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No. 03-1507

In The
Supreme Court of the United States

LEON HARRELL,

Petitioner,

vs.

CNA INSURANCE COMPANIES; CONTINENTAL CASUALTY COMPANY; QUORUM HEALTH GROUP, INC. D/B/A CAROLINAS HOSPITAL SYSTEM; QHG OF SOUTH CAROLINA, INC. D/B/A CAROLINA HOSPITAL SYSTEM; CAROLINAS HOSPITAL SYSTEM GROUP LONG TERM DISABILITY PLAN,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

Petitioner Leon Harrell's long term disability benefits were terminated first by the Plan's Case Manager and later by the Plan's Appeals Committee. The termination by the Case Manager was found by the District Court to be an abuse of discretion and reinstatement of benefits was awarded to Petitioner for that period of improper denial. In contrast, the District Court found the Appeals Committee's subsequent decision to also terminate Petitioner's benefits was proper. The Appeals Committee's decision was based on additional information, different from the information which served as the basis of the Case Manager's decision. The Appeals Committee's decision was not merely an affirmation of the Case Manager's decision. Petitioner asserts that because the Case Manager's decision was an abuse of discretion, the subsequent Appeals Committee's decision was also, as a matter of law, an abuse of discretion. This issue is not one on which this Petition should be granted. ERISA requires the Court to weigh each decision of termination of benefits against the abuse of discretion standard. The Court properly conducted this analysis and determined that the Appeals Committee's decision was proper. Prior to its decision, the Appeals Committee requested "objective medical information" in support of Petitioner's claim of permanent medical disability. Instead of objective medical information, Petitioner supplied a letter from his physician to the Appeals Committee which contradicted previously submitted medical records. Petitioner failed to submit any medical records at all in support of his appeal to the Appeals Committee. In such a case, the Appeals Committee appropriately decided to terminate benefits.

QUESTIONS PRESENTED – Continued

Petitioner's Questions 2 and 4 deal with whether a Request for Production filed in litigation can be considered a written request for plan documents under ERISA, 29 U.S.C. § 1132(c), thus triggering the statutory penalty for a failure to respond. This issue has been plainly decided by the 7th Circuit in *Verkuilen v. South Shore Bldg.*, 122 F.3d 410, 411 (7th Cir. 1997) ("An interrogatory under Fed.R.Civ.P. 33 [and a request for production of documents under Fed.R.Civ.P. 34] is a lawyer-to-lawyer device, rather than a participant-to-administrator device," and failure to respond to the discovery request has its own consequences.) The lower court here adopted the reasoning of that 7th Circuit decision and the 4th Circuit affirmed that decision. There is no other Circuit Court decision to the contrary. There is no reason for this Court to grant certiorari to decide this issue.

Finally, Petitioner seeks certiorari on the issue of whether Petitioner should have been awarded attorneys' fees. Petitioner bases his entitlement to attorneys' fees solely on the fact that the Court imposed liability and awarded damages on one of Petitioner's causes of action. Even though that is the issue presented by Petitioner, the facts set forth in the question do not accurately represent the facts of this case and the answer to that question is inconsequential because success on the merits is not a factor to be considered in awarding attorneys' fees under ERISA. The District Court properly applied the factors guiding the Court's discretion in awarding fees in ERISA cases. Success on the merits is not a factor in that analysis. Instead, the District Court is to consider the relative merits of the parties' positions. The District Court appropriately

QUESTIONS PRESENTED – Continued

and accurately applied this factor to the facts of this case. Because the Appeals Committee's termination was not an abuse of discretion, the District Court properly held that this factor weighed in favor of Respondents. This question presented by Petitioner does not present a novel issue or a split in circuit court decisions, nor does the Petitioner argue that different factors should have been considered by the Court in determining a fee award. The Court should not grant certiorari on this question or any of the other questions presented by Petitioner.

TABLE OF CONTENTS

	Page
Questions Presented for Review	i
Table of Contents	iv
Table of Authorities	v
Opinion and Judgment Below	1
Errors and Omissions in Petitioner's Statement of the Case	2
Reasons for Denying the Writ	8
Argument	9
I. The Appeals Committee's Discretionary Decision To Uphold The Termination Of Petitioner's Benefits Was The Result Of A Deliberate, Principled Reasoning Process And Is Not, As A Matter Of Law, An Abuse Of Discretion As A Result Of The District Court's Determination That The Case Manager's Decision To Terminate Benefits Was An Abuse Of Discretion	9
II. The Case Law On The Issue, Which The District Court Followed, Holds That Discovery Requests Cannot Be Considered A "Written Request" Under 29 U.S.C. § 1024(b)(4)	11
III. The District Court Properly Applied The Test For Awarding Costs And Attorney's Fees Under ERISA	12
Conclusion	14

TABLE OF AUTHORITIES

Page

CASES

Gooden v. Provident Life & Accident Ins. Co., 250 F.3d 329 (5th Cir. 2001) 9

Kamler v. H/N Telecom. Serv. Inc., 2001 U.S. Dist. LEXIS 21328 (N.D. Ill. June 25, 2001) 11

Quesinberry v. Life Ins. Co., 987 F.2d 1017 (4th Cir. 1993) 12

Verkuilen v. South Shore Bldg., 122 F.3d 410 (7th Cir. 1997) 8, 11

OTHER AUTHORITIES

29 U.S.C. § 1024(b)(4) 1, 11

29 U.S.C. § 1132, et seq. 1, 8, 11, 12

Webster's New Explorer Medical Dictionary (1999) 2, 3

OPINION AND JUDGMENT BELOW

Petitioner originally filed this action in the State Court for recovery of plan benefits under ERISA, and recovery for alleged violations of 29 U.S.C. §§ 1024(b)(4) and 1132(c). Respondents removed the case to the United States District Court for South Carolina, Florence Division. Respondents moved for summary judgment as to Respondents' Counterclaim that it was entitled to, as a matter of law, the amount representing the social security benefits received by the Petitioner while he was receiving benefits from Respondents. The District Court granted the Respondents' Motion.

The Parties agreed to the trial of this case by submission of briefs to the District Court. The District Court ruled that the Case Manager's decision to terminate benefits was an abuse of discretion, upheld the Appeals Committee's decision, and awarded the Petitioner the disability benefits that should have been paid between the Case Manager's decision and the Appeals Committee's decision.

Thereafter, Respondents moved for enforcement of the previously granted Summary Judgment Motion, and Petitioner moved for Reconsideration. The District Court denied Petitioner's Motion to Reconsider by Order dated May 14, 2003 and entered an Amended Judgment the following day. The Amended Judgment reflects that Petitioner was awarded Six Thousand, Forty-Four and 8/100 ($6,044.08) dollars, plus pre and post-judgment interest, in addition to and contrasted by the previous award to the Respondents, inclusive of attorneys' fees and interest, totaling Twenty-Two Thousand, One Hundred Thirteen and 07/100 ($22,113.07) dollars.

Petitioner timely filed a Notice of Appeal to the United States Court of Appeals for the Fourth Circuit on June 3, 2003. On February 2, 2004, the United States Court of Appeals for the Fourth Circuit affirmed the District Court's Orders.

ERRORS AND OMISSIONS IN PETITIONER'S STATEMENT OF THE CASE

Petitioner includes an abbreviated version of facts within the Statement of the Case and disperses various other factual statements throughout the argument. However, Petitioner misstates certain facts and fails to include all of the facts important to the Court's decision in this matter. These facts are set forth below.

Petitioner was a Cardiac Catheterization Laboratory Technician at Carolinas Hospital ("Carolinas") in Florence, South Carolina. Carolinas was owned and operated by Quorum Health Group, Inc. ("Quorum"). Quorum provided an optional Long Term Disability Program ("Plan") to its employees through CNA.

Petitioner suffered from osteomyelitis[1] of his left heel and underwent corrective surgery on January 7, 1997. After his surgery, Petitioner's physician estimated that he would be out of work for approximately two weeks.

[1] Osteomyelitis is defined as "an infectious inflammatory disease of bone often of bacterial origin that is marked by local death and separation of tissue." *Webster's New Explorer Medical Dictionary*, 485 (1999).

Petitioner's doctor later amended his expected return to work date to March 1, 1997.

The Plan covering Petitioner contained a 150-day elimination period. Accordingly, Petitioner was not eligible to receive benefits until May 17, 1997. On April 12, 1997, Petitioner submitted an additional Employee's Statement detailing his health problems. In his statement, Petitioner claimed he continued to suffer from osteomyelitis as well as sarcoidosis.[2]

On April 11, 1997, CNA notified Petitioner that his claim for benefits had been approved. It also advised Petitioner that a nurse case manager would be discussing Petitioner's progress with his doctor. Further, Petitioner was reminded that under the Plan, he had to "provide proof of your continuing disability." Lastly, Petitioner was informed that he would receive benefits of 60% of his monthly salary on the eighteenth of each month beginning June 18, 1997. In order to receive benefits, the Plan required Petitioner to meet the Plan's definition of "total disability." Under the terms of the Plan, Petitioner could receive twenty-four months of benefits if he was totally disabled from his own occupation. If Petitioner continued to be totally disabled beyond that benefits period, he would be eligible to continue receiving benefits only if he was unable to be " . . . gainfully employed in *any* occupation for

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[2] Sarcoidosis is defined as "a chronic disease of unknown cause that is characterized by the formation of nodules resembling true tubercles esp. in the lymph nodes, lungs, bones and skin – called also Boeck's sarcoid." *Webster's New Explorer Medical Dictionary*, 614-615 (1999).

which he is or becomes qualified by education, training or experience." (emphasis added).

Petitioner was paid his first monthly benefits check on June 18, 1997. Petitioner's doctors' diagnoses and the medical evidence supported a finding that Petitioner was totally disabled under the Plan at that time. A nurse, Terri Barresi, and a Case Manager, Pam Ward, were assigned to the case. Nurse Barresi and Ms. Ward continued to monitor Petitioner's progress and worked with his doctors in assessing Petitioner's improvement.

In September 1997, Nurse Barresi and Ms. Ward were advised by Petitioner's physician, Dr. J.P. Booth, that he expected Petitioner to return to work on October 1, 1997. Dr. Booth believed that "part time work would be great at this point" and suggested a transition back to full time work at Carolinas. Based on this information, Petitioner's benefits were set to be discontinued. However, after reviewing additional medical evidence, Nurse Barresi and Ms. Ward decided this new information supported the continuation of benefits to Petitioner. This is one example of how Respondents continued Petitioner's benefits as long as he met the criteria set forth in the Plan.

Benefits were paid to Petitioner through the Spring of 1998. Petitioner's physician, Dr. Booth, continued to provide Respondents with progress reports and to discuss the case with Nurse Barresi and Ms. Ward. Petitioner misstates in his statement of the case that the record did contain medical evidence of disability and no evidence to the contrary. In fact, the evidence to the contrary came in Dr. Booth's April 13, 1998 report in which he noted Petitioner's marked improvement. For example, the report

states that Petitioner's depression was reasonably controlled,[3] his heart sounded normal, lungs were clear and his blood pressure was within normal limits. Importantly, Dr. Booth's report did not contain any specific limitations supporting continuous total disability. Upon receiving the April 13, 1998 report, Nurse Barresi and Ms. Ward discussed the status of Petitioner's improvement. It was determined that Petitioner no longer met the Plan's requirement of total disability, but that he would be paid another payment "in good faith with a letter of termination." A termination letter was drafted by Ms. Ward ("Case Manager") and approved by Nurse Barresi. The letter was dated May 15, 1998, and was sent to Petitioner. The letter detailed the specific reasons for termination of benefits, explained his rights to appeal under the Plan, and urged him to submit additional evidence supporting his claim if he disagreed with the decision.

Petitioner received the May 15, 1998 termination letter on or about May 18, 1998, and called to speak with the Case Manager and Nurse Barresi. Petitioner also went to see Dr. Booth within two days of receiving the letter. Petitioner told Dr. Booth he was concerned that his benefits had been cut off.

About this time, on May 20, 1998, Dr. Booth spoke with Nurse Barresi about Petitioner's condition. During this conversation, Dr. Booth told Nurse Barresi that he was familiar with the type of work requirements of a

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[3] After Petitioner stopped working in December of 1996, he had bouts with severe depression which eventually required in-patient treatment at Greenland Park in October of 1997. Greenland Park is a psychiatric ward at McLeod Hospital.

Cardiac Catheterization Laboratory Technician and that it would be therapeutic for Petitioner to return to work. Further, Dr. Booth agreed that Petitioner's blood pressure, diabetes and depression were controlled and that his lungs were clear at his last examination. In sum, Dr. Booth echoed his findings detailed in his April 13, 1998 report and confirmed CNA's decision that Petitioner was no longer totally disabled.

On May 26, 1998, Petitioner notified CNA that he was appealing its decision to stop his benefits. In a letter dated May 28, 1998, CNA acknowledged the receipt of Petitioner's appeal and forwarded all additional documents and the file to the Appeals Committee, which is totally separate from the Case Manager and Nurse Barresi.

On June 1, 1998, Nurse Barresi sent a letter to Dr. Booth confirming their May 20, 1998 conversation in which Dr. Booth stated that "it would be therapeutic for Mr. Harrell to return to work." That same day, Dr. Booth faxed Nurse Barresi's letter back to her with handwritten notes retracting his May 20, 1998 opinions. In his retraction, Dr. Booth stated that Petitioner's depression was the cause of his being unable to return to work.[4] There is no mention of any limitations caused by osteomyelitis or sarcoidosis. It is important to note that between Dr. Booth's recommendation that Petitioner return to work

[4] Nonetheless, the May 21, 1998 OHA Psychiatric Review Technique Form submitted by Frederick W. Christianson indicates that Petitioner's depression and mental health results in only "slight" restrictions on activities of daily living and social functioning. This independent finding supports Dr. Booth's April 13, 1998 diagnosis and the May 15, 1998 decision to terminate Petitioner's benefits.

and his retraction, Petitioner visited Dr. Booth and expressed concern about losing his benefits.

In addition to his handwritten notes faxed to Nurse Barresi on June 1, 1998, Dr. Booth sent her a letter on June 1, 1998. In this letter, Dr. Booth wrote that Petitioner was "unable to perform any heavy meaningful work." However, Petitioner's job description states that the physical demands are "medium," not "heavy."

On August 5, 1998, the Appeals Committee notified Petitioner that his appeal had been denied. The letter gave very specific reasons for the Appeals Committee's decision. For example, the Appeals Committee noted lack of medical evidence supporting certain ailments, as well as the absence of specific test results and information that would verify Petitioner's claims of continued total disability. More specifically, the Appeals Committee noted that it had been over two years since an ACE[5] test detailing the status of Petitioner's sarcoidosis had been provided, that it had not been given objective medical evidence of Petitioner's sarcoid arthritis, nor was it provided with routine supporting criteria such as a report of the Global Assessment of Functioning Scale per the DSM IV[6] relating to claims of continued depression. Because there was no objective medical evidence provided to the Case Manager and the Appeals Committee that supported a finding that Petitioner was totally disabled, his appeal was denied. Petitioner misstates in his statement of the case that Dr.

[5] An angiotension-converting enzyme test determines the status and severity of sarcoidosis.

[6] Diagnostic and Statistical Manual of Mental Disorders.

Booth performed a medical exam on Petitioner after the denial by the Case Manager. No record of a medical examination was submitted to the Appeals Committee. Petitioner only submitted a letter from Dr. Booth that was conclusory and contradicted his previously submitted medical records.

REASONS FOR DENYING THE WRIT

There are no compelling reasons to grant the Petition for Writ of Certiorari in this case and many reasons to deny the Petition. In his Petition under the section entitled "Reasons for Granting the Writ of Certiorari," Petitioner sets forth all of his arguments on the merits. The only issue which could be construed as fitting within the purview of a compelling reason upon which this Petition could be granted is Petitioner's assertion that the issue of whether discovery requests can trigger liability under 29 U.S.C. § 1132(c) is a novel issue. Petitioner asserts that it is a novel issue because it is an issue that can occur again and it is important to future parties. However, the issue has been decided by the 7th Circuit which held that discovery requests cannot trigger liability under ERISA, 29 U.S.C. § 1132(c). *Verkuilen v. South Shore Bldg.*, 122 F.3d 410 (7th Cir. 1997). The trial court here ruled consistently with and in reliance on this 7th Circuit decision. No circuit court has issued a decision to the contrary. Therefore, this issue is not a novel issue requiring review by this Court.

The other issues presented by Petitioner for review do not present novel issues nor do they present circumstances

where there is a split among the circuits, nor any other compelling reasons requiring the grant of this Petition.

ARGUMENT

I. THE APPEALS COMMITTEE'S DISCRETIONARY DECISION TO UPHOLD THE TERMINATION OF PETITIONER'S BENEFITS WAS THE RESULT OF A DELIBERATE, PRINCIPLED REASONING PROCESS AND IS NOT, AS A MATTER OF LAW, AN ABUSE OF DISCRETION AS A RESULT OF THE DISTRICT COURT'S DETERMINATION THAT THE CASE MANAGER'S DECISION TO TERMINATE BENEFITS WAS AN ABUSE OF DISCRETION.

Petitioner's claim that the Appeals Committee's decision was an abuse of discretion as a matter of law because it affirmed, although on different information, the Case Manager's decision is unsupported by law or fact and Petitioner fails to provide any support for such a proposition. The Appeals Committee properly requested Petitioner to submit objective medical evidence in support of his appeal. *See Gooden v. Provident Life & Accident Ins. Co.*, 250 F.3d 329, 335 (5th Cir. 2001) (an insurer must be allowed to hold a claimant to his burden of proof as to whether the claimant fits within the policy's provisions.). Petitioner failed to meet this burden. He attempted to convince the Appeals Committee to reverse the Case Manager's decision with phone calls and letters from himself and his doctor, none of which were accompanied by any objective medical information. The lack of such objective medical evidence provided the basis for the Appeals

Committee's decision to uphold the denial of Petitioner's benefits.

Petitioner further alleges that the Appeals Committee refused to accept Dr. Booth's medical examination and report, presumably from Dr. Booth's letter of June 1, 1998, as medical documentation. Clearly, the Appeals Committee did consider this report. However, when considered along with Dr. Booth's previous statements, which weighed in favor of termination of Petitioner's benefits for disability, the Appeals Committee arrived at the reasoned, principled decision that the Petitioner had failed to provide the requisite objective documentation which supported his claim that he could no longer perform the duties of his occupation. Clearly, the decision of the Appeals Committee to deny Petitioner's disability benefits did not constitute an abuse of discretion.

There is no support for the issue on which Petitioner requests this writ be granted. The Appeals Committee's decision is not as a matter of law an abuse of discretion merely because the Case Manager's decision which it upheld was found to be an abuse of discretion. Each decision denying benefits was entitled to review by the Court. The Appeals Committee's decision was made by different people relying on different evidence and supported by different information than the decision made by the Case Manager. There is no de facto abuse of discretion and the Petition should not be granted.

II. THE CASE LAW ON THE ISSUE, WHICH THE DISTRICT COURT FOLLOWED, HOLDS THAT DISCOVERY REQUESTS CANNOT BE CONSIDERED A "WRITTEN REQUEST" UNDER 29 U.S.C. § 1024(b)(4).

The 7th Circuit has held that litigation discovery requests do not constitute a request for plan documents to trigger penalties under ERISA. "An interrogatory under Fed.R.Civ.P. 33 [and a request for production of documents under Fed.R.Civ.P. 34] is a lawyer-to-lawyer device, rather than a participant-to-administrator device," and failure to respond to the discovery request has its own consequences. *Verkuilen v. South Shore Bldg.*, 122 F.3d 410, 411 (7th Cir. 1997); *See also Kamler v. H/N Telecom. Serv. Inc.*, 2001 U.S. Dist. LEXIS 21328 (N.D. Ill. June 25, 2001). Indeed, "[n]othing but confusion could come from treating complaints and interrogatories as ERISA demands, and replacing [F.R.C.P.] Rules 11 and 37 with the penalty provisions of § 1132(c)." *Verkuilen* at 412.

The Petitioner never made a request for the Plan to the Plan Administrator as contemplated by the statutory provision. Instead, Petitioner sought the Plan through discovery and Respondents provided the plan to Petitioner under the only proper discovery request in which it was sought.

Petitioner's original request for the production of the governing plan was issued by Petitioner's original counsel on May 4, 1999. In July of 1999, Petitioner moved to relieve his original counsel and hired present counsel as a replacement. Based on Petitioner's original counsel's

request, Respondent did not take any action in the case until replacement counsel was hired.[7]

Petitioner then submitted a second discovery request for the plan on October 4, 1999, which was outside of the time allowed in the District Court's scheduling order in this matter. A new scheduling order was consented to by all parties and a timely third request for the plan was issued by the Petitioner on April 10, 2000. By letter dated May 9, 2000, Respondents produced a copy of the plan as requested.

III. THE DISTRICT COURT PROPERLY APPLIED THE TEST FOR AWARDING COSTS AND ATTORNEY'S FEES UNDER ERISA.

A district court, in its discretion, may award attorney's fees and costs under ERISA. *See* 29 U.S.C. § 1132(g)(1); *Quesinberry v. Life Ins. Co.*, 987 F.2d 1017 (4th Cir. 1993). The five factors employed to guide the district court's discretion are:

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[7] Mr. Kozacki, Petitioner's initial counsel, served the first discovery requests on Respondents on May 4, 1999. Shortly thereafter, he notified Respondents that he intended to withdraw and shortly thereafter Petitioner executed a Termination of Representation, all prior to the date on which initial discovery responses were due. Before withdrawing, Mr. Kozacki reasonably requested that defense counsel refrain from pursuing the case until Petitioner retained replacement counsel. Defense counsel complied with this request, holding off filing motions, proceeding with discovery as well as waiting to notice depositions until notified that Mr. Johnson would be assuming Petitioner's representation. In September, defense counsel contacted Mr. Johnson to inquire how the delay created by change in counsel should be dealt with as well as informed Mr. Johnson that the discovery deadline was about to expire.

(1) degree of opposing parties' culpability or bad faith;

(2) ability of opposing parties to satisfy an award of attorneys' fees;

(3) whether an award of attorneys' fees against the opposing parties would deter other persons acting under similar circumstances;

(4) whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and

(5) the relative merits of the parties' positions.

Id. at 1029.

Petitioner requests that this Petition be granted on the issue of whether judgment on an issue of liability is success on the merits for a Court to consider in awarding fees. However, as shown above, success on the merits is not one of the factors to guide the Court's discretion over fee awards. One of the factors does require the Court to consider the relative merits of the parties' position. The District Court properly weighed this factor. There was a finding that the Case Manager's decision was an abuse of discretion. However, the other judgment in the case, the summary judgment award to Respondent, totals more than twenty-two thousand dollars. Additionally, the District Court found that there was no abuse of discretion as to the ultimate decision by the Appeals Committee. Thus, the District Court's determination to weigh this factor in favor of the Respondents was proper.

CONCLUSION

For the foregoing reasons, the Petition for Writ of Certiorari should be denied.

Respectfully submitted,

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